Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DR WILLIAM L SMITH
2825 IH 10 EAST SUITE 112
BEAUMONT TX 77702

Respondent Name

ACE AMERICAN INSURANCE CO

Carrier's Austin Representative Box

Box Number 15

MFDR Tracking Number

M4-12-1831-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On **11/14/2011**, Impairment Resources sent a notice to the insurance adjuster to expedite the bill as soon as possible…sent HICFA and report to the insurance adjuster 'Linda Coleman' on **04/29/2011**…sent the HICFA to the adjuster on **05/04/2011**…sent a final notice letter to the adjuster stating that the bill is still outstanding and has not been paid. Attached to the letter is the 32 Form, HICFA, report, confirmations, and narratives. Sent on **12/14/2011**."

Amount in Dispute: $950.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "No payment has been issued to the provider as the modifiers are not are the bill…It was determined that no additional payment is due as the provider is not using the appropriate codes."

Response Submitted by: Ace ESIS, 6600 E. Campus Circle, Suite 200, Irving, TX 75063

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 20, 2011	CPT Code 99456-W5 CPT Code 99456-W5 CPT Code 99456-W5 CPT Code 99456-W5	$500.00 $150.00 $150.00 $150.00	$350.00 $0.00 $0.00 $0.00
TOTAL		$950.00	$350.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for the reimbursement of workers' compensation specific codes, services and programs provided on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated February 7, 2012
   - 1 – The procedure code is inconsistent with the modifier used or a required modifier is missing.
   - 1 – Modifiers required for this procedure. Resubmit service with appropriate modifier.

Issues

1. Were the services in dispute appropriately billed?
2. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
3. Is the requestor entitled to additional reimbursement for the disputed services under 28 Texas Administrative Code §134.204?

Findings

1. The requestor billed the amount of $950.00 for CPT Code 99456-W5 X 4 for a Division ordered Designated Doctor examination for 1 body areas/units each in box 24G of the CMS-1500. Review of the documentation supports that MMI was assigned and three (3) body areas were rated. The neck and back, arm and skin are the three areas claimed as rated. Review of the submitted documentation supports that Maximum Medical Improvement (MMI) was assigned and per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is $350.00.

   CPT code 99456-W5 required a "MI" as an additional modifier for multiple impairment ratings.

   Per 28 Texas Administrative Code §134.204 states in part (j)(4))B)

   (4) The following applied for billing and reimbursement of an IR evaluation.

   (B) When multiple IRs are required as a component of a designated doctor examination under §130.6 of this title (relating to Designated Doctor Examinations for Maximum Medical Improvement and/or Impairment Ratings), the designated doctor shall bill for the number of body areas rated and be reimbursed $50 for each additional IR calculation. Modifier 'MI' shall be added to the MMI evaluation CPT code.

2. Review of the submitted documentation supports that the Division ordered the examination, yet any reimbursement methodology allowance per 28 Texas Administrative Code §134.204 for individual services was contingent upon the use of the modifiers explained in the entire rule. The medical bills submitted by the requestor for review do not reflect that the appropriate modifiers were applied according to the rule, therefore, reimbursement is disallowed.
3. The respondent has previously reimbursed the amount of $0.00 for the disputed CPT code 99456-W5. Therefore, the requestor is entitled to reimbursement of $350.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $350.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $350.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April 25, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.